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8 UNITED STATES DISTRICT COURT  
9 CENTRAL DISTRICT OF CALIFORNIA  
10

11 MARCOS JESUS SILVA, ) NO. SA CV 18-1244-E  
12 Plaintiff, )  
13 v. ) MEMORANDUM OPINION  
14 COMMISSIONER OF SOCIAL SECURITY ) AND ORDER OF REMAND  
15 ADMINISTRATION, )  
16 Defendant. )  
17

18 Pursuant to sentence four of 42 U.S.C. section 405(g), IT IS  
19 HEREBY ORDERED that Plaintiff's and Defendant's motions for summary  
20 judgment are denied, and this matter is remanded for further  
21 administrative action consistent with this Opinion.  
22

23 PROCEEDINGS  
24

25 Plaintiff filed a complaint on July 17, 2018, seeking review of  
26 the Commissioner's denial of benefits. The parties consented to  
27 proceed before a United States Magistrate Judge on August 14, 2018.  
28 Plaintiff filed a motion for summary judgment on November 21, 2018.

1 Defendant filed a motion for summary judgment on December 27, 2018.  
2 The Court has taken the motions under submission without oral  
3 argument. See L.R. 7-15; "Order," filed July 20, 2018.

#### 4 5 **BACKGROUND**

6  
7 Plaintiff asserts disability since December 27, 2013, based on,  
8 inter alia, alleged pain and weakness from lower back and neck  
9 problems, fibromyalgia and osteoarthritis (Administrative Record  
10 ("A.R.") 202-07, 220, 464, 477, 558-66, 583, 896, 900, 908). The  
11 Court previously remanded Plaintiff's disability claim for further  
12 administrative consideration of the opinion of one of Plaintiff's  
13 treating physicians, Dr. Murali Raju. See A.R. 655-62 (Memorandum  
14 Opinion and Order of Remand and Judgment filed on August 17, 2016, in  
15 Silva v. Commissioner, SA CV 16-441-E (the "Prior Action")); see also  
16 A.R. 448-51 (Dr. Raju's opinion). As the Court pointed out in the  
17 Prior Action, Dr. Raju had opined that Plaintiff's lumbar degenerative  
18 disc disease limits Plaintiff to standing and walking no more than  
19 four hours in an eight hour workday and would cause Plaintiff to be  
20 absent from work approximately twice per month. See id. The Court  
21 did not reach any other issue then raised except to find that reversal  
22 with a directive for the immediate payment of benefits would not be  
23 appropriate (A.R. 662, n.2).

24  
25 The Appeals Council subsequently vacated the Commissioner's final  
26 decision and remanded the case to an Administrative Law Judge ("ALJ")  
27 for further proceedings consistent with this Court's order (A.R. 683).  
28 The Appeals Council also instructed the ALJ to consolidate Plaintiff's

1 claim with a subsequent claim for benefits filed on April 6, 2015  
2 (id.).

3  
4 On remand, a new ALJ reviewed the record and heard testimony from  
5 Plaintiff and a vocational expert (A.R. 464-78, 546-96). Plaintiff  
6 testified to pain and limitations of allegedly disabling severity  
7 (A.R. 555-73). The ALJ found that Plaintiff has "severe" degenerative  
8 disc disease of the cervical and lumbar spine with neural foraminal  
9 narrowing and facet arthropathy, mild cerebral atrophy, fibromyalgia,  
10 arthritis, osteoarthritis of the hip, post-concussive syndrome,  
11 chronic headaches, disorder of the sacrum, obesity, bibasilar  
12 atelectasis with trace right pleural effusion, hepatic steatosis  
13 (mildly enlarged liver), depression, and post-traumatic stress  
14 disorder ("PTSD") (A.R. 467). The ALJ found that Plaintiff retains a  
15 residual functional capacity for light work limited to:

16 (1) occasionally climbing ramps and stairs, balancing, stooping,  
17 kneeling, crouching and crawling; (2) no climbing of ladders, ropes or  
18 scaffolds; (3) tasks with a reasoning level of 2 or less;  
19 (4) occasional direct public contact; and (5) low stress jobs defined  
20 as having only occasional decision-making duties and changes in the  
21 work setting. See A.R. 469-76 (rejecting Plaintiff's allegations as  
22 "not entirely consistent with the medical evidence and other evidence  
23 in the record," and giving "greatest weight" to non-examining state  
24 agency physician opinions and "least weight" to Dr. Raju's opinion).  
25 The ALJ deemed Plaintiff capable of performing work as a "marker,"  
26 "power screwdriver operator," and "housekeeping cleaner," and, on that  
27 basis, denied disability benefits through September 19, 2017 (A.R.  
28 477-78 (adopting vocational expert testimony at A.R. 577-78)).

1 In analyzing Plaintiff's residual functional capacity, the ALJ  
2 did not even mention Dr. Raju's opinion that Plaintiff would be absent  
3 from work two times per month (A.R. 475-76). Plaintiff submitted  
4 "exceptions" to the Appeals Council, arguing, inter alia, that the ALJ  
5 failed properly to consider Plaintiff's subjective complaints and Dr.  
6 Raju's opinions (A.R. 931-36). The Appeals Council considered the  
7 exceptions but denied review, discerning no reason to assume  
8 jurisdiction (A.R. 454). The Appeals Council refused to "consider and  
9 exhibit" new evidence Plaintiff had submitted, finding that the  
10 evidence assertedly did not show a reasonable probability of a  
11 different outcome (A.R. 454). The Appeals Council also found not  
12 relevant certain newly submitted records postdating the ALJ's decision  
13 (A.R. 454).

#### 14 15 STANDARD OF REVIEW

16  
17 Under 42 U.S.C. section 405(g), this Court reviews the  
18 Administration's decision to determine if: (1) the Administration's  
19 findings are supported by substantial evidence; and (2) the  
20 Administration used correct legal standards. See Carmickle v.  
21 Commissioner, 533 F.3d 1155, 1159 (9th Cir. 2008); Hoopai v. Astrue,  
22 499 F.3d 1071, 1074 (9th Cir. 2007); see also Brewes v. Commissioner,  
23 682 F.3d 1157, 1161 (9th Cir. 2012). Substantial evidence is "such  
24 relevant evidence as a reasonable mind might accept as adequate to  
25 support a conclusion." Richardson v. Perales, 402 U.S. 389, 401  
26 (1971) (citation and quotations omitted); see also Widmark v.  
27 Barnhart, 454 F.3d 1063, 1066 (9th Cir. 2006).

28 ///

1 If the evidence can support either outcome, the court may  
2 not substitute its judgment for that of the ALJ. But the  
3 Commissioner's decision cannot be affirmed simply by  
4 isolating a specific quantum of supporting evidence.  
5 Rather, a court must consider the record as a whole,  
6 weighing both evidence that supports and evidence that  
7 detracts from the [administrative] conclusion.

8  
9 Tackett v. Apfel, 180 F.3d 1094, 1098 (9th Cir. 1999) (citations and  
10 quotations omitted).

## 11 12 DISCUSSION

13  
14 After consideration of the record as a whole, the Court reverses  
15 the Administration's decision in part and remands the matter for  
16 further administrative proceedings. As discussed below, the  
17 Administration materially erred in evaluating the evidence of record.

### 18 19 I. Summary of the Medical Record.

20  
21 The available medical record dates back to May of 2013 (A.R. 293-  
22 302). At that time, Plaintiff presented to the emergency room for  
23 lower extremity pain and weakness radiating from the low back (id.).  
24 Plaintiff associated these problems with a 1994 work-related injury  
25 for which Plaintiff had been treated until 1997 (id.). Plaintiff did  
26 not then have health insurance or a primary care physician (A.R. 294).

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1       The record following that first emergency room visit reflects  
2 consistent complaints of radiating back pain and findings of  
3 degenerative disease in the lumbar and cervical spine. See, e.g.,  
4 A.R. 291, 294, 321, 325-26, 330, 345, 354, 373, 379, 389, 401, 411,  
5 422, 426, 428, 443, 941, 945, 1238, 1431, 1433, 1435, 1554, 1624,  
6 1626, 1829, 1836, 1839, 1842, 1846, 1857, 1861, 1864, 2070, 2114  
7 (Plaintiff's complaints); see also A.R. 301-02 (May, 2013 lumbar spine  
8 CT scan showing degenerative changes, disc space narrowing at L4-L5  
9 and L5-S1, and facet joint arthropathy); A.R. 361-62 (March, 2014  
10 lumbar spine MRI showing multilevel degenerative disc disease and  
11 facet arthropathy most significant at L4-L5, where there is mild to  
12 moderate neural foraminal narrowing and central canal stenosis without  
13 impingement, and mild fatty atrophy of the paraspinal musculature);  
14 A.R. 1148-49 (April, 2015 lumbar spine MRI showing moderate to severe  
15 facet arthrosis and ligamentous flavum hypertrophy at L4-L5, minimal  
16 anterolisthesis of L4 on L5, moderate stenosis of the right neural  
17 foramen and right lateral recess, moderate facet arthrosis at L5-S1,  
18 and minimal anterolisthesis of L5 - S1); A.R. 1156-57 (December, 2015  
19 lumbar spine x-ray showing narrowing disc space at L5-S1, facet  
20 arthritis at L4-L5 and L5-S1, lumbar spondylosis at L3-L4, generalized  
21 osteopenia, and a wedge deformity at T12); A.R. 1763-64 (August, 2016  
22 lumbar spine MRI showing moderate degenerative disc disease and facet  
23 spondylosis from L3-L4 through L5-S1, bilateral lateral recess  
24 narrowing at L4-L5, moderate L3-L4 through L5-S1 bilateral neural  
25 foraminal narrowing, and unchanged minimal anterolisthesis of L5 on  
26 S1); A.R. 416 (October, 2014 cervical spine x-rays showing mild  
27 degenerative changes); A.R. 1330-31 (March, 2015 cervical spine MRI  
28 showing mild multilevel degenerative disc disease with mild to

1 moderate narrowing of the spinal canal from C3-C7); A.R. 1761-63  
2 (August, 2016 cervical spine MRI showing congenital narrowing of the  
3 spinal canal mainly at C4-C5, mild degenerative changes, mild to  
4 moderate canal stenosis at C5-C6 and mild spinal canal stenosis at C4-  
5 C5, and mild to moderate left neural foraminal stenosis at C5-C6).  
6 Plaintiff reportedly has used a cane for ambulation since February of  
7 2013 due to weakness and pain in the right leg (A.R. 295, 345-46, 391,  
8 945, 1201, 1208, 1225, 1238, 1690, 1693, 1818-19, 1857, 1981, 1994,  
9 2011, 2016, 2019, 2038, 2054, 2068).

10  
11 Plaintiff began regular treatment at LAC-USC Medical Center in  
12 June of 2013 for alleged back and knee pain (A.R. 320-42).  
13 Plaintiff's doctor reviewed the May, 2013 lumbar spine CT scan and  
14 noted on examination that Plaintiff had tenderness in the lumbar area  
15 and both knees, and an unstable gait without an assistive device (A.R.  
16 320-21). Plaintiff was prescribed Ultram (Tramadol), ordered to avoid  
17 heavy lifting, and referred for an orthopedic evaluation (A.R. 321-  
18 22). In January of 2014, Plaintiff's doctor reportedly completed a  
19 General Relief "disability" form for disability through April of 2014  
20 (A.R. 372-73). This form is not in the record.

21  
22 Consultative examiner Dr. Ibrahim Yashruti prepared a complete  
23 orthopaedic evaluation dated February 7, 2014 (A.R. 345-50).  
24 Plaintiff complained of burning, throbbing, dull and sharp back pain,  
25 bilateral hip and knee pain, chest pain, weakness in the legs  
26 aggravated by sitting, standing, walking, bending and lifting,  
27 dizziness, nausea and problems controlling his bladder (A.R. 345).  
28 Plaintiff reported injuring his back in 1994 while lifting a patient

1 (A.R. 345). Plaintiff reportedly had been using a cane constantly  
2 since February of 2013, stating that he could not walk without the  
3 cane (A.R. 345-46). Plaintiff was taking Tramadol, Ranitidine,  
4 Ibuprofen and Methocarbamol (A.R. 345).

5  
6 On examination, Plaintiff had limited range of motion in the  
7 cervical spine, tenderness and limited range of motion in the  
8 lumbosacral spine, "popping" in the low back upon palpation of the  
9 knees, and positive straight leg raising, with limited effort reported  
10 on several tests (A.R. 346-49). X-rays showed mild healed compression  
11 at T12 and "very mild" scoliosis of L5-S1 (A.R. 349).<sup>1</sup> Dr. Yashruti  
12 opined that Plaintiff had no orthopedic findings to justify  
13 Plaintiff's movements and reaction to examination, and that Plaintiff  
14 could ambulate without a cane (A.R. 350). Dr. Yashruti found  
15 Plaintiff capable of medium work (i.e., lifting 50 pounds  
16 occasionally, 25 "degrees" (pounds) occasionally, standing and walking  
17 six hours a day, sitting six hours a day, with frequent squatting,  
18 kneeling, crouching and crawling, and no limitations in reaching with  
19 his arms and manipulating with his hands) (A.R. 350). Dr. Yashruti  
20 stated that Plaintiff would benefit from a neurologic evaluation (A.R.  
21 350).

22  
23 Plaintiff thereafter presented to the UC Irvine Emergency  
24 Department in March of 2014 for back pain (A.R. 354-59, 361-62,  
25 378-87). A lumbar spine MRI showed multilevel degenerative disc  
26 disease and facet arthropathy most significant at L4-L5, where there

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27  
28 <sup>1</sup> It appears that Dr. Yashruti did not review Plaintiff's  
May, 2013 lumbar spine CT scan.



1 was mild to moderate neural foraminal narrowing, with lateral recess  
2 narrowing and central canal stenosis without impingement, and mild  
3 fatty atrophy of the paraspinal musculature (id.). Plaintiff was  
4 prescribed acetaminophen-hydrocodone and ordered to follow up with his  
5 primary doctor (A.R. 354).

6  
7 Dr. Josephina Choa of AltaMed regularly treated Plaintiff from  
8 May of 2014 through at least July of 2015 (A.R. 389-94, 418-41, 1014-  
9 69, 1318-23). Dr. Choa diagnosed, inter alia, obesity, PTSD, lumbar  
10 disc disease, neck pain, chronic radiculopathy, urinary incontinence  
11 and memory loss, and referred Plaintiff to various specialists (A.R.  
12 389, 392, 420, 429, 440-41, 1034, 1322).

13  
14 One of those specialists was neurosurgeon Dr. Raju, who evaluated  
15 Plaintiff in July of 2014 (A.R. 411-14). Plaintiff complained of  
16 progressively worsening back pain, radiating down both legs with  
17 associated numbness and tingling and bladder incontinence (A.R. 411).  
18 Dr. Raju reviewed Plaintiff's lumbar spine MRI and noted on  
19 examination that Plaintiff had decreased range of motion in his back  
20 due to pain, but a gait and station "within normal limits" (with no  
21 mention of whether Plaintiff was using a cane) (A.R. 411-12). Dr.  
22 Raju assessed lumbago and degeneration of the lumbar or lumbosacral  
23 intervertebral disc, with a note to consider facet blocks for  
24 Plaintiff's facet arthropathy and degenerative changes (A.R. 412).  
25 Dr. Raju referred Plaintiff to a pain management doctor and suggested  
26 follow up after the facet blocks (A.R. 413).

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28 ///

1 Plaintiff saw pain management specialist Dr. Kais Alsharif in  
2 September of 2014 (A.R. 401-08). Plaintiff reported a history of  
3 progressive, daily, constant back pain for over 20 years, worse with  
4 physical activity, prolonged walking or standing, radiating down his  
5 legs with intermittent numbness and tingling and weakness in the legs  
6 (A.R. 401). Plaintiff said Norco and Tramadol gave him nausea and  
7 dizziness (A.R. 401). Plaintiff also said that he then was taking  
8 Tramadol, Ibuprofen and Robaxin, and that he had not had surgery or  
9 injections (A.R. 401). On examination, Plaintiff reportedly had  
10 tenderness in the lumbar spine, positive facet loading, positive  
11 straight leg raising tests, positive Faber test, negative Waddell's  
12 sign, and a normal gait (with use of a cane) (A.R. 402). Dr. Alsharif  
13 reviewed Plaintiff's lumbar spine MRI and assessed lumbar facet  
14 syndrome, lumbar spondylosis, lumbar degenerative disc disease, lumbar  
15 radiculitis and disorders of the sacrum (A.R. 403). Dr. Alsharif  
16 opined that Plaintiff's presentation was consistent with lumbar  
17 radiculopathy, facet arthropathy and sacroiliac dysfunction (A.R.  
18 403). Dr. Alsharif prescribed Tylenol #3 and recommended a bilateral  
19 S.I. (sacroiliac) injection (A.R. 403-04). Plaintiff returned on  
20 September 30, 2014, for a bilateral sacroiliac joint epidural steroid  
21 injection (A.R. 405-08).

22  
23 Dr. Raju completed a one-page General Relief "Report of  
24 Examination" form dated September 30, 2014 (A.R. 414). This form  
25 stated that Plaintiff had lumbar degenerative disc disease with severe  
26 pain since 1994, which was considered permanent, and rendered  
27 Plaintiff unsuitable for any employment, with the following specific  
28 limitations: "no lifting, prolonged sitting or walking" (A.R. 414).

1 Plaintiff returned to Dr. Alsharif in December of 2014, reporting  
2 that Tylenol #3 was helping his pain but also reporting that the  
3 improvement he received from the sacroiliac injection lasted only one  
4 week (A.R. 994). Plaintiff then was taking Tylenol #3 and Robaxin  
5 (A.R. 995). Findings on examination were unchanged from the prior  
6 examinations (A.R. 995). Dr. Alsharif continued Plaintiff's  
7 medications and gave Plaintiff a L5-S1 epidural injection (A.R. 996-  
8 98).

9  
10 Plaintiff followed up with Dr. Raju in January of 2015 (A.R.  
11 1624-25). Plaintiff reported improving back pain but persistent neck  
12 pain, and stated that his symptoms were unchanged despite having  
13 epidural steroid injections since his last visit with Dr. Raju (A.R.  
14 1624). On examination, Plaintiff reportedly had normal strength and  
15 was able to ambulate without assistance (A.R. 1624). There is no  
16 indication whether Plaintiff then was using a cane (A.R. 1624). Dr.  
17 Raju assessed cervicalgia, indicated that Plaintiff should continue  
18 with his series of epidural steroid injections, and referred Plaintiff  
19 for physical therapy and a cervical spine MRI (A.R. 1624-25).

20  
21 Dr. Raju completed a "Medical Assessment of Ability to Do  
22 Work-Related Activities (Physical)" form dated January 12, 2015 (A.R.  
23 448-51). Dr. Raju opined that Plaintiff could frequently lift and  
24 carry up to 20 pounds, sit for two hours at one time without  
25 interruption, stand for two hours at one time without interruption,  
26 walk for two hours at one time without interruption, for a total of  
27 six hours sitting in a workday and four hours standing/walking in a  
28 workday (A.R. 448-49). Dr. Raju opined that Plaintiff could

1 occasionally stoop, crouch, kneel and crawl, never climb, frequently  
2 balance, and occasionally push and pull depending on the weight (A.R.  
3 450). Dr. Raju further opined that Plaintiff could not work in  
4 environments with unprotected heights, moving machinery, exposure to  
5 marked changes in temperature and humidity, or dust, fumes and gases,  
6 and would have "mild" restrictions in driving due to Plaintiff's  
7 narcotic medications (A.R. 451). Dr. Raju opined that Plaintiff would  
8 likely miss work "[a]bout twice a month" due to his condition (A.R.  
9 451).

10  
11 Plaintiff returned to Dr. Alsharif in March of 2015, reporting  
12 significant improvement for only approximately two weeks from the L5-  
13 S1 injection but also saying that his pain was controlled with  
14 medication (A.R. 1109). Examination findings were unchanged (A.R.  
15 1110-11). Dr. Alsharif continued Plaintiff's medications without  
16 giving any additional injections (A.R. 1111).

17  
18 When Plaintiff returned to Dr. Raju later in March of 2015,  
19 Plaintiff reported no improvement in his neck and low back pain since  
20 the last visit with Dr. Raju (A.R. 1626). Plaintiff reported that he  
21 had completed the series of epidural steroid injections with "mild  
22 improvement" for only 1.5 weeks, and had attended one physical therapy  
23 session without improvement (A.R. 1626). Examination results were  
24 unchanged (A.R. 1627). Dr. Raju reviewed Plaintiff's March, 2015  
25 cervical spine MRI, which showed mild multilevel degenerative disc  
26 disease with mild to moderate narrowing of the spinal canal from C3-C7  
27 (A.R. 1330-31), and "[d]iscussed with patient about continued  
28 follow-up with pain management for conservative treatment options, and

1 continuing with [physical therapy]" (A.R. 1627).<sup>2</sup>

2  
3 In April of 2015, Plaintiff consulted with orthopedic surgeon Dr.  
4 Adam Holleran, who reviewed Plaintiff's March, 2015 cervical spine MRI  
5 (A.R. 941-43). On examination, Plaintiff reportedly had mild loss of  
6 cervical and lumbar lordosis, moderate tenderness to palpation of the  
7 cervical and lumbar spine, muscle spasm, limited range of motion with  
8 pain, but intact sensation and strength (A.R. 942). Dr. Holleran  
9 diagnosed cervical and lumbar degenerative disc disease, requested a  
10 lumbar spine MRI, prescribed Meloxicam, and referred Plaintiff for  
11 pain management and physical therapy, with a note to return as needed  
12 (A.R. 943).<sup>3</sup>

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15  
16 <sup>2</sup> Consultative neurologist Dr. Nancy Vu evaluated  
17 Plaintiff in March of 2015 (A.R. 945). Plaintiff complained of  
18 chronic daily diffuse and frontal headaches following a history  
19 of multiple concussions, depression, poor balance, back problems  
20 with bilateral leg numbness, pain, weakness, obesity,  
21 homelessness, tinnitus, dizziness, vertigo and an unsteady gait  
22 requiring a cane (A.R. 945). On examination, Plaintiff  
23 reportedly was anxious, tense but cooperative, depressed with  
24 slight inattention, had mild proximal leg weakness, and ambulated  
25 slowly with a cane (A.R. 945). Dr. Vu diagnosed post concussion  
26 syndrome, chronic headaches, and assessed a history of depression  
27 and poor memory with "?" re psychosis (A.R. 945). Dr. Vu ordered  
28 a brain CT scan which showed mild cerebral atrophy (A.R. 945-47).  
Plaintiff returned for follow up in May and August of 2015 with  
no reported changes (A.R. 1125-28).

25 <sup>3</sup> As summarized above, Plaintiff's April, 2015 lumbar  
26 spine MRI showed moderate to severe facet arthrosis and  
27 ligamentous flavum hypertrophy at L4-L5, minimal anterolisthesis  
28 of L4 on L5, moderate stenosis of the right neural foramen and  
right lateral recess, moderate facet arthrosis at L5-S1, and  
minimal anterolisthesis of L5 on S1 (A.R. 1148-49).

1 Plaintiff returned to Dr. Alsharif in June of 2015, reporting no  
2 changes (A.R. 1105-08). Dr. Alsharif continued Plaintiff's  
3 medications with a note that a consultation with a spine surgeon (Dr.  
4 Massoudi) was pending (A.R. 1107). It appears that Plaintiff did not  
5 consult with another surgeon until 2016. In March of 2016,  
6 neurological surgeon Dr. Peyman Tabrizi examined Plaintiff, later  
7 reviewed Plaintiff's April, 2016 lumbar spine MRI,<sup>4</sup> and recommended  
8 against any surgical intervention in favor of "continued conservative  
9 management" with physical therapy and possible rheumatology evaluation  
10 and treatment for arthritis (A.R. 1521-22).

11  
12 In October of 2015, Plaintiff began regular treatment with Dr.  
13 Rye-Ji Kim and others at UC Irvine Health, after Plaintiff presented  
14 to the UC Irvine emergency room in September of 2015 for neck, back  
15 and right leg pain (A.R. 1227-40, 1981-2142). Dr. Kim reviewed  
16 Plaintiff's March, 2014 lumbar spine MRI, and referred Plaintiff for  
17 pain management, orthopedic, urologic, and neurologic surgery  
18 consultations, and a psychiatry consultation (A.R. 1163, 1229-30).

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21  
22 <sup>4</sup> The April, 2016 lumbar spine MRI does not appear to be  
23 in the record. According to Dr. Tabrizi, this MRI showed  
24 evidence of L2 hemangioma, L3-L4 disc dessication with a 1-mm  
25 disc bulge and mild to moderate facet hypertrophy bilaterally,  
26 mild bilateral neural foraminal stenosis, L4-L5 moderate to  
27 severe facet arthrosis with ligamentum flavum hypertrophy and  
28 minimal anterolisthesis of L4 and L5, moderate stenosis of the  
right neural foramen and mild left neural foraminal stenosis, L5-  
S1 dessication with subtle anterolisthesis of L5 over S1, and  
moderate facet hypertrophy bilaterally causing moderate bilateral  
neural foraminal stenosis. See A.R. 1521.

1 Plaintiff was treated by the Pain Medicine Specialty Group  
2 monthly from December of 2015 through at least January of 2017 (A.R.  
3 1426-50, 1554-61, 1574-75, 1815-47). Plaintiff reported chronic neck,  
4 low back and leg pain radiating to the upper and lower extremities,  
5 aggravated by prolonged sitting, standing, walking, lifting, bending  
6 and driving (A.R. 1435). Plaintiff also reported that lumbar epidural  
7 injections had provided short term relief only and that Tylenol with  
8 codeine prescribed by his pain doctor was not helpful (A.R. 1435). On  
9 examination, Plaintiff reportedly had tenderness in the paraspinal  
10 muscles, positive facet maneuver, and no sensory deficits (A.R. 1436).  
11 Plaintiff was assessed with lumbar and cervical radiculopathy, and  
12 prescribed Norco and Gabapentin (A.R. 1432, 1434, 1436-37). By  
13 February of 2016, Plaintiff reported that his pain medications were  
14 not effective and Plaintiff refused any further injections, so his  
15 Norco dose was increased and he was given a Lidoderm patch (A.R.  
16 1428-29). In March of 2016, Plaintiff reported that the Lidoderm  
17 patch was working well and his pain was controlled with medications  
18 (A.R. 1426). In April and May of 2016, Plaintiff's pain reportedly  
19 was stable on his medications (A.R. 1556, 1560). From June through  
20 October of 2016, Plaintiff reported neck pain radiating to his  
21 bilateral upper extremities, low back pain radiating to the bilateral  
22 lower extremities, and no desire for any spine injections or surgery  
23 (A.R. 1554, 1836, 1839, 1842, 1846). Examination results were  
24 unchanged and his medications were continued (A.R. 1554-55, 1836-37,  
25 1839-40, 1842-43, 1846-47). In December of 2016, Plaintiff reported  
26 that he had slipped and hurt his right hip two weeks earlier and he  
27 was still having pain with walking (A.R. 1829). A hip x-ray was  
28 ordered and his medications were continued (A.R. 1829-30). When

1 Plaintiff returned in January of 2017, he reported that his right hip  
2 was still hurting (A.R. 1826). A right hip x-ray showed  
3 osteoarthritis and mild osteopenia (A.R. 1826, 1870-71). Plaintiff's  
4 medications were continued (A.R. 1827).

5  
6 Meanwhile, Plaintiff presented to Dr. David Kilgore at UC Irvine  
7 Health in December of 2015 for an "Integrative Medicine Consultation"  
8 (A.R. 1198-1207). On examination, Plaintiff reportedly had difficulty  
9 rising from a chair, ambulated slowly with a cane, had a kyphotic  
10 posture, positive straight leg raising tests, limited range of motion,  
11 multiple myofascial trigger points, and was unable to stand completely  
12 erect (A.R. 1201). Dr. Kilgore assessed chronic neck and low back  
13 pain, degenerative disc and facet arthritis, depression, pre-diabetes,  
14 obesity, chronic urge urinary incontinence, and possible multi-trauma  
15 early onset dementia with CT scan evidence of cerebral atrophy (A.R.  
16 1202).

17  
18 Plaintiff returned to Dr. Kilgore in March of 2016 for follow up  
19 (A.R. 1178-89). Plaintiff reportedly had undergone "conservative"  
20 treatment including medication, physical therapy and epidural  
21 injections with decreased activity and without sustainable  
22 improvements to pain function or quality of life (A.R. 1179).  
23 Plaintiff was using Lidocaine patches, Hydrocodone and Gabapentin for  
24 pain, using a cane to walk, and was taking Abilify, Sertraline and  
25 Mirtazapine for depression (A.R. 1178, 1180-84). Plaintiff was  
26 homeless (A.R. 1178, 1180).

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28 ///



1 Consulting neurologist Dr. Mark Farag evaluated Plaintiff in June  
2 of 2016 for short and long term memory issues dating back to a bicycle  
3 accident in 2008 or 2009 (A.R. 1712-16). On examination, Plaintiff  
4 reportedly had a Mini Mental Status Examination ("MMSE") score of  
5 29/30, with 2/3 recall, and a narrow base gait with cane assistance  
6 (A.R. 1713-14). Dr. Farag reviewed Plaintiff's lumbar spine MRI and  
7 brain CT scan, and opined that Plaintiff was experiencing normal  
8 variations in mental status and attention, given Plaintiff's ability  
9 to take care of himself and navigate travel and government systems  
10 without assistance, opining that any primary neurological disorder is  
11 at an "imperceptibly early stage" (A.R. 1715).

12  
13 Consulting rheumatologist Dr. Sarah Hwang evaluated Plaintiff in  
14 August and September of 2016 (A.R. 1772-81). Examination revealed  
15 swelling and/or tenderness in fingers, elbows, cervical and lumbar  
16 spine, knees, ankles and feet and positive trigger points (A.R. 1774).  
17 Dr. Hwang assessed obesity, fibromyalgia and depression, as well as  
18 spinal stenosis (A.R. 1775). Dr. Hwang found no evidence of  
19 rheumatoid arthritis (A.R. 1780).

20  
21 Consulting neurologist Dr. Jack Lin evaluated Plaintiff in  
22 December of 2016 (A.R. 1818-24). Plaintiff reported episodes of brain  
23 "fogginess" and intermittent forgetfulness, but no loss of functioning  
24 from the prior neurological evaluation (A.R. 1818). Plaintiff's MMSE  
25 score was 28/30 and his recall was 2/3 (A.R. 1819). Plaintiff again  
26 was noted to have a narrow base gait with cane assistance (A.R. 1819).  
27 Dr. Lin found it unlikely that Plaintiff is suffering from a  
28 neurocognitive disorder but referred Plaintiff for a more complete

1 memory workup (A.R. 1821).

2  
3 Plaintiff consulted in March and June of 2017 with neurologist  
4 Dr. Chuang Kuo Wu for memory issues (A.R. 1999-2004, 2091-98). An  
5 April, 2017 brain MRI showed no acute lesions but mild cerebral  
6 cortical atrophy (A.R. 2000, 2061). A May, 2017 EEG study was normal  
7 (A.R. 2054-55). Dr. Wu assessed memory loss and possible mild  
8 neurocognitive disorder (A.R. 2001).<sup>5</sup>

9  
10 State agency physicians reviewed Plaintiff's claim while the  
11 Prior Action was pending and found Plaintiff capable of light work as  
12 of May of 2016 (A.R. 628-49). However, the state agency physicians  
13 did not review Dr. Raju's January, 2015 opinion stating that Plaintiff  
14 had greater limitations and would be absent from work twice each  
15 month. See A.R. 633, 644, 647 (state agency physicians indicating  
16 that there was no opinion evidence for review). State agency  
17 physicians reconsidered Plaintiff's claim in September of 2016 - after  
18 this Court's remand order in the Prior Action but before the Appeals

19  
20 <sup>5</sup> The record also contains a "Mental Assessment" form  
21 dated August 8, 2017, by Sandra P. Klein, Ph.D. (A.R. 2151-55).  
22 There are no treatment notes from Dr. Klein. Dr. Klein diagnosed  
23 an "unspecified neurocognitive disorder" based on the presence of  
24 cerebral atrophy, depression, chronic neck and low back pain, and  
25 possible post-multi-trauma early dementia (A.R. 2154). Dr. Klein  
26 opined that Plaintiff has various limits in his understanding and  
27 memory, concentration and persistence, social interaction and  
28 adaptation (A.R. 2151-54). Dr. Klein explained, "Mr. Marcos  
Silva exhibits impaired sustained & divided attention ability.  
This undermines most other cognitive domains and exacerbates his  
previous limited cognitive ability. Chronic pain and depression  
contributes [sic] to an inability to problem solve, make  
decisions, remember detailed instructions, and follow-through on  
completing tasks at hand. Physical limitations also contribute  
to an inability to perform tasks normally." (A.R. 2155).

1 Council remanded the case (A.R. 655-62, 683). At that time, the state  
2 agency physicians again found Plaintiff capable of light work and  
3 again failed to acknowledge Dr. Raju's opinion. See A.R. 663-79  
4 (stating there was no opinion evidence for review).

5  
6 **II. Summary of Plaintiff's Testimony and Statements.**

7  
8 At the most recent administrative hearing in August of 2017,  
9 Plaintiff testified that he received government relief and lived in  
10 his car (A.R. 550-51). Plaintiff said that in 1989, he and his  
11 brother walked in on a robbery and were shot. Plaintiff was shot five  
12 times, causing him to lose 60 percent of his feeling on his left side,  
13 and his brother was shot once, leaving his brother a paraplegic (A.R.  
14 555-56).

15  
16 Plaintiff complained of daily neck pain radiating to his lower  
17 back, head and arms following several car accidents, pain and weakness  
18 in his arms and hands following a bicycle accident, difficulty  
19 breathing upon bending due to fractured ribs that did not heal  
20 correctly, trouble gripping his walking cane, daily mid-back pain  
21 radiating down to his legs aggravated by walking, sitting and lying  
22 down, leg pain and weakness, and knee pain from several falls  
23 radiating down to his foot aggravated by walking and standing, worse  
24 on the right side than the left (A.R. 558-65). Plaintiff said that he  
25 has used a cane constantly since 2012 on his right side because he has  
26 problems balancing and has fallen, and he does not want to put all his  
27 weight on his right knee (A.R. 565-68). Plaintiff estimated that he  
28 could stand for five minutes without a cane but insisted he would need

1 the cane when he moves (A.R. 568). Plaintiff said when he tries to  
2 walk without a cane he drags his feet and stumbles (A.R. 568).  
3 Plaintiff said that he suffers back pain from sitting continuously and  
4 must either lie down or move around to relieve the pain (A.R. 568-69).  
5 Plaintiff estimated that he could sit continuously for 30 minutes  
6 (A.R. 569). Plaintiff said that he lies down for 15 to 20 minutes  
7 every hour during a typical day (A.R. 570). Plaintiff could take the  
8 bus to his brother's house to shower and get his mail (A.R. 570-71).  
9 Plaintiff said he has trouble sleeping, feels depressed, has problems  
10 concentrating and thinking, and cannot remember what he reads (A.R.  
11 555, 572-73).

12  
13 In a Function Report form dated in April of 2016, Plaintiff  
14 reported that he was homeless, ate two "ready made" meals a day, took  
15 public transportation, shopped 10 to 15 minutes a day for food, and  
16 tried to take short walks and exercise if possible (A.R. 879-81).  
17 Plaintiff reported that he had trouble bending, stooping, sitting,  
18 standing and walking, that rheumatoid arthritis in his hands made it  
19 hard to care for his hair or shave or hold things,<sup>6</sup> and that he had  
20 trouble with his concentration and memory and getting along with  
21 others (A.R. 879, 882-83). Plaintiff reported that he walked with a  
22 cane and could walk 200 feet before needing to rest up to 30 minutes

23 ///

24 ///

25 ///

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26  
27 <sup>6</sup> This Function Report predates Plaintiff's rheumatology  
28 examination, where he was found to have swelling and tenderness  
in his fingers and assessed with fibromyalgia (A.R. 1777-80).

1 (A.R. 883-84).<sup>7</sup>

2  
3 **III. The ALJ Erred in Discounting Plaintiff's Testimony and Statements**  
4 **Regarding the Severity of Plaintiff's Symptoms Without Stating**  
5 **Legally Sufficient Reasons for Doing So.**  
6

7 Where, as here, an ALJ finds that a claimant's medically  
8 determinable impairments reasonably could be expected to cause some  
9 degree of the alleged symptoms of which the claimant subjectively  
10 complains, any discounting of the claimant's complaints must be  
11 supported by "specific, cogent" findings. See Berry v. Astrue, 622  
12 F.3d 1228, 1234 (9th Cir. 2010); Lester v. Chater, 81 F.3d 821, 834  
13 (9th Cir. 1995); but see Smolen v. Chater, 80 F.3d 1273, 1282-84 (9th  
14 Cir. 1996) (indicating that ALJ must state "specific, clear and  
15 convincing" reasons to reject a claimant's testimony where there is no  
16  
17

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18 <sup>7</sup> In a Function Report form from December of 2013, when  
19 Plaintiff was not homeless, Plaintiff reported that on a typical  
20 day he woke up, ate, showered, took his medications, tried to  
21 read, watched television, listened to the radio, took a short  
22 walk if he could, and made a sandwich for lunch (A.R. 239).  
23 Plaintiff reportedly could make sandwiches and canned soup,  
24 drive, and shop in stores for 30 minutes (A.R. 241-42).  
25 Plaintiff reportedly did not go to places where he has to sit,  
26 stand or walk for prolonged times (A.R. 244). Plaintiff  
27 indicated that he had trouble lifting, could walk one block or  
28 less before needing to rest for 15 minutes or more, needed a cane  
for assistance when he walked, and could pay attention for five  
to 10 minutes (A.R. 244-45). Similarly, in an undated Pain  
Questionnaire, Plaintiff reported that he could only do minimal  
walking, driving and shopping, and no household chores, but he  
could make cold sandwiches and warm soups in the microwave (A.R.  
228-29). Plaintiff reported that he could walk less than one  
block, stand for five to 10 minutes, and sit for 15 to 30 minutes  
at a time (A.R. 229).

evidence of malingering).<sup>8</sup> Generalized, conclusory findings do not suffice. See Moisa v. Barnhart, 367 F.3d 882, 885 (9th Cir. 2004) (the ALJ's credibility findings "must be sufficiently specific to allow a reviewing court to conclude the ALJ rejected the claimant's testimony on permissible grounds and did not arbitrarily discredit the claimant's testimony") (internal citations and quotations omitted); Holohan v. Massanari, 246 F.3d 1195, 1208 (9th Cir. 2001) (the ALJ must "specifically identify the testimony [the ALJ] finds not to be credible and must explain what evidence undermines the testimony"); Smolen v. Chater, 80 F.3d at 1284 ("The ALJ must state specifically which symptom testimony is not credible and what facts in the record lead to that conclusion."); see also Social Security Ruling 16-3p (eff. March 28, 2016).<sup>9</sup>

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<sup>8</sup> In the absence of an ALJ's reliance on evidence of "malingering," most recent Ninth Circuit cases have applied the "clear and convincing" standard. See, e.g., Brown-Hunter v. Colvin, 806 F.3d 487, 488-89 (9th Cir. 2015); Burrell v. Colvin, 775 F.3d 1133, 1136-37 (9th Cir. 2014); Treichler v. Commissioner, 775 F.3d 1090, 1102 (9th Cir. 2014); Ghanim v. Colvin, 763 F.3d 1154, 1163 n.9 (9th Cir. 2014); Garrison v. Colvin, 759 F.3d 995, 1014-15 & n.18 (9th Cir. 2014); see also Ballard v. Apfel, 2000 WL 1899797, at \*2 n.1 (C.D. Cal. Dec. 19, 2000) (collecting earlier cases). In the present case, the ALJ's findings are insufficient under either standard, so the distinction between the two standards (if any) is academic.

<sup>9</sup> Social Security Rulings ("SSRs") are binding on the Administration. See Terry v. Sullivan, 903 F.2d 1273, 1275 n.1 (9th Cir. 1990). SSR 16-3p superseded SSR 96-7p, but may have "implemented a change in diction rather than substance." R.P. v. Colvin, 2016 WL 7042259, at \*9 n.7 (E.D. Cal. Dec. 5, 2016); see also Trevizo v. Berryhill, 871 F.3d 664, 678 n.5 (9th Cir. 2017) (suggesting that SSR 16-3p "makes clear what our precedent already required").

1 Here, the ALJ discounted Plaintiff's testimony and statements as  
2 "not entirely consistent with the medical evidence and other evidence  
3 in the record" (A.R. 473-74). The ALJ stated: (1) Plaintiff's  
4 statements concerning the intensity, persistence and limiting effects  
5 of his symptoms on his ability to ambulate assertedly were  
6 inconsistent with the objective medical evidence; (2) the degree of  
7 Plaintiff's subjective complaints assertedly was "not comparable" to  
8 the "conservative" treatment Plaintiff sought; (3) Plaintiff's  
9 activities of daily living (e.g., taking nightly walks, using public  
10 transportation and shopping in stores for food) assertedly were  
11 inconsistent with Plaintiff's alleged limitations; and (4) Plaintiff's  
12 alleged memory loss assertedly was "inconsistent" with the objective  
13 medical record (A.R. 474-75).

14  
15 With regard to the second stated reason, a limited course of  
16 treatment sometimes can justify the rejection of a claimant's  
17 testimony, at least where the testimony concerns physical problems.  
18 See, e.g., Burch v. Barnhart, 400 F.3d 676, 681 (9th Cir. 2005) (lack  
19 of consistent treatment, such as where there was a three to four month  
20 gap in treatment, properly considered in discrediting claimant's back  
21 pain testimony); Meanel v. Apfel, 172 F.3d 1111, 1114 (9th Cir. 1999)  
22 (in assessing the credibility of a claimant's pain testimony, the  
23 Administration properly may consider the claimant's failure to request  
24 treatment and failure to follow treatment advice) (citing Bunnell v.  
25 Sullivan, 947 F.2d 341, 346 (9th Cir. 1991) (en banc)); Matthews v.  
26 Shalala, 10 F.3d 678, 679-80 (9th Cir. 1993) (permissible credibility  
27 factors in assessing pain testimony include limited treatment and  
28 minimal use of medications); see also Johnson v. Shalala, 60 F.3d

1 1428, 1434 (9th Cir. 1995) (absence of treatment for back pain during  
2 half of the alleged disability period, and evidence of only  
3 "conservative treatment" when the claimant finally sought treatment,  
4 sufficient to discount claimant's testimony).

5  
6 In the present case, however, it is highly doubtful Plaintiff's  
7 treatment accurately may be characterized as "conservative" within the  
8 meaning of Ninth Circuit jurisprudence (even though Plaintiff's  
9 doctors sometimes used the term "conservative" to reference any  
10 treatment not involving surgery, see A.R. 1521, 1627). As detailed  
11 above, the record shows that Plaintiff regularly sought treatment from  
12 several providers throughout the alleged disability period, followed  
13 up as ordered and complied with all non-surgical treatment  
14 suggestions, including physical therapy, narcotic pain medication and  
15 multiple epidural injections.<sup>10</sup> Although doctors have not recommended  
16 surgery for Plaintiff's lumbar spine, Plaintiff's treatment does not  
17 appear to have been "routine" or "conservative," as those terms are  
18 employed in case law. See, e.g., Childress v. Colvin, 2014 WL  
19 4629593, at \*12 (N.D. Cal. Sept. 16, 2014) ("[i]t is not obvious  
20 whether the consistent use of [Norco] (for several years) is  
21

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22 <sup>10</sup> While Plaintiff reported in March of 2015 to Dr.  
23 Alsharif that medications controlled his pain (A.R. 1109),  
24 Plaintiff reported to Dr. Raju that same month that he had no  
25 improvement in his pain (A.R. 1626). Plaintiff also reported  
26 from March through May of 2016 either that Norco and Lidocaine  
27 patches were controlling his pain or that he was stable on his  
28 medications (A.R. 1426, 1556, 1560). However, any relief  
Plaintiff reportedly experienced appears to have been only  
temporary since Plaintiff reported radiating neck and back pain  
not relieved by medications from June of 2016 onward (A.R. 1554,  
1826, 1836, 1839, 1842, 1846, 2070, 2114).



1 'conservative' or in conflict with Plaintiff's pain testimony");  
2 Aguilar v. Colvin, 2014 WL 3557308, at \*8 (C.D. Cal. July 18, 2014)  
3 ("It would be difficult to fault Plaintiff for overly conservative  
4 treatment when he has been prescribed strong narcotic pain  
5 medications"); Christie v. Astrue, 2011 WL 4368189, at \*4 (C.D. Cal.  
6 Sept. 16, 2011) (refusing to characterize as "conservative" treatment  
7 including use of narcotic pain medication and epidural injections).  
8

9 With regard to the third stated reason, inconsistencies between  
10 admitted activities and claimed incapacity properly may impugn the  
11 accuracy of a claimant's testimony and statements under certain  
12 circumstances. See, e.g., Thune v. Astrue, 499 Fed. App'x 701, 703  
13 (9th Cir. 2012) (ALJ properly discredited pain allegations as  
14 contradicting claimant's testimony that she gardened, cleaned, cooked,  
15 and ran errands); Stubbs-Danielson v. Astrue, 539 F.3d 1169, 1175 (9th  
16 Cir. 2008) (claimant's "normal activities of daily living, including  
17 cooking, house cleaning, doing laundry, and helping her husband in  
18 managing finances" provided sufficient explanation for discounting  
19 claimant's testimony). Yet, it is difficult to reconcile Ninth  
20 Circuit opinions discussing when a claimant's admitted activities may  
21 and may not justify a discounting of the claimant's testimony and  
22 statements. Compare Stubbs-Danielson v. Astrue with Vertigan v.  
23 Halter, 260 F.3d 1044, 1049-50 (9th Cir. 2001) ("the mere fact that a  
24 plaintiff has carried on certain daily activities, such as grocery  
25 shopping, driving a car, or limited walking for exercise, does not in  
26 any way detract from her credibility as to her overall disability");  
27 see also Diedrich v. Berryhill, 874 F.3d 634, 642-43 (9th Cir. 2017)  
28 (daily activities of cooking, cleaning, vacuuming, washing dishes,

1 shopping and cleaning a cat's litter box insufficient to discount the  
2 claimant's subjective complaints).

3  
4 Contrary to the ALJ's stated findings in the present case,  
5 Plaintiff's admitted activities of taking short daily walks, using  
6 public transportation, shopping for 10 to 15 minutes a day for food,  
7 and making "ready made" meals when he is not homeless, do not properly  
8 undermine Plaintiff's subjective complaints. See Revels v. Berryhill,  
9 874 F.3d 648, 667-68 (9th Cir. 2017) (ALJ erred in finding disparity  
10 between claimant's reported activities and symptom testimony where the  
11 claimant indicated she could use the bathroom, brush her teeth, wash  
12 her face, take her children to school, wash dishes, do laundry, sweep,  
13 mop, vacuum, go to doctor's appointments, visit her mother and father,  
14 cook, shop, get gas, and feed her dogs; ALJ failed to acknowledge the  
15 claimant's explanation, consistent with her symptom testimony, that  
16 she could complete only some tasks in a single day and regularly  
17 needed to take breaks). There is no material inconsistency between  
18 Plaintiff's admitted activities and Plaintiff's claimed incapacity.

19  
20 With regard to the first and fourth stated reasons, asserted  
21 inconsistencies between a claimant's subjective complaints and the  
22 objective medical evidence can be a factor in discounting a claimant's  
23 subjective complaints, but cannot "form the sole basis." See Burch v.  
24 Barnhart, 400 F.3d at 681; Rollins v. Massanari, 261 F.3d 853, 857  
25 (9th Cir. 2001). Where there is an alleged inconsistency between the  
26 medical evidence and a claimant's subjective complaints, the ALJ must  
27 make a specific finding identifying the testimony the ALJ finds not  
28 credible and linking the rejected testimony to parts of the medical

1 record supporting the ALJ's non-credibility determination. See  
2 Brown-Hunter v. Colvin, 806 F.3d at 494 (holding it was legal error  
3 for ALJ to fail to make such a link) (citations omitted).  
4

5 Here, the ALJ stated that, although Plaintiff complained he had  
6 limited ambulation and used a cane, several examinations reportedly  
7 noted a normal gait and station, and full motor strength and intact  
8 sensation in the lower extremities (A.R. 474). The ALJ also stated  
9 that, although Plaintiff complained of memory loss, Plaintiff's mental  
10 status examinations "did not demonstrate cognitive deficits" (A.R.  
11 474-75). These isolated findings do not accurately capture the tenor  
12 of the medical record as a whole, which also includes findings of  
13 lumbar radiculopathy (A.R. 403, 1432, 1434, 1436-37), lumbar stenosis  
14 (A.R. 361-62, 1148-49, 1521, 1775), mild leg weakness (A.R. 945), and  
15 fibromyalgia (signs and symptoms of which include "cognitive or memory  
16 problems" and "muscle weakness"; see SSR 12-2p at \*3 & n.9 (discussing  
17 fibromyalgia diagnostic criteria)) (A.R. 1775), and assessment of  
18 memory loss and possible mild neurocognitive disorder based in part on  
19 Plaintiff's brain MRI (A.R. 2000-01). In any event, the isolated  
20 findings cited by the ALJ are not inconsistent with Plaintiff's  
21 claimed problems with balancing and walking limitations. The ALJ's  
22 findings are not a legally sufficient reason to discount Plaintiff's  
23 subjective complaints. See, e.g., Cash v. Berryhill, 2018 WL 571940,  
24 at \*8-11 (S.D. Cal. Jan. 26, 2018), adopted, 2018 WL 1101087 (S.D.  
25 Cal. Feb. 26, 2018) (finding ALJ erred in failing to articulate  
26 consideration of fibromyalgia's unique symptoms in concluding evidence  
27 undermined Plaintiff's statements alleging disabling pain and weakness  
28 and memory problems); see generally Revels v. Berryhill, 874 F.3d at

1 656-57 (explaining that those suffering from fibromyalgia have muscle  
2 strength, sensory functions, and reflexes that are normal, and  
3 experience symptoms including widespread pain and cognitive or memory  
4 problems that "wax and wane"); Garrison v. Colvin, 759 F.3d 995, 1017  
5 (9th Cir. 2014) ("[I]t is error to reject a claimant's testimony  
6 merely because symptoms wax and wane in the course of treatment.  
7 Cycles of improvement and debilitating symptoms are a common  
8 occurrence, and in such circumstances it is error for an ALJ to pick  
9 out a few isolated instances of improvement . . . and to treat them as  
10 a basis for concluding a claimant is capable of working.") (citing  
11 Holohan v. Massanari, 246 F.3d 1195, 1205 (9th Cir. 2001)).

12  
13 Defendant cites to: (1) Dr. Yashruti's observation that Plaintiff  
14 declined to walk on his toes, heels or squat, and declined other  
15 physical testing - where Dr. Yashruti had found no orthopedic evidence  
16 to justify Plaintiff's movements (without reviewing Plaintiff's lumbar  
17 spine CT scan showing degeneration) (A.R. 346-50);<sup>11</sup> and (2) asserted  
18 absence from the record of a prescription for a cane (but see A.R.  
19 1690, 1693 (Dr. Kim's record noting that the pharmacy had ordered a  
20 large handle cane for Plaintiff)). Defendant argues that Plaintiff's  
21 asserted lack of cooperation with Dr. Yashruti and "self-prescription"  
22 of his cane are reasons to discount Plaintiff's subjective statements.  
23 See Defendant's Motion, pp. 3-4. Because the ALJ did not specify such  
24 matters as reasons to discount Plaintiff's credibility (see A.R. 473-

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25  
26  
27 <sup>11</sup> The ALJ discounted Dr. Yashruti's opinion that  
28 Plaintiff was capable of performing medium work as not consistent  
with the medical record as a whole or more recent diagnostic  
studies (A.R. 475).

1 75), the Court cannot uphold the credibility determination on the  
2 basis of such considerations. See Pinto v. Massanari, 249 F.3d 840,  
3 847 (9th Cir. 2001) (the court "cannot affirm the decision of an  
4 agency on a ground that the agency did not invoke in making its  
5 decision").

6  
7 The Court is unable to conclude that the ALJ's failure to state  
8 legally sufficient reasons for discounting Plaintiff's credibility was  
9 harmless. "[A]n ALJ's error is harmless where it is inconsequential  
10 to the ultimate non-disability determination." Molina v. Astrue, 674  
11 F.3d 1104, 1115 (9th Cir. 2012) (citations and quotations omitted).  
12 Here, the vocational expert testified that, if someone were off task  
13 20 percent of the work day, there would be no jobs the person could  
14 perform (A.R. 583). The vocational expert did not testify there are  
15 jobs performable by a person as limited as Plaintiff claims to be  
16 (A.R. 577-92).

17  
18 **IV. The ALJ Also Erred in Evaluating the Medical Evidence.**

19  
20 In determining Plaintiff's residual functional capacity, the ALJ  
21 summarized: (1) Dr. Raju's January, 2015 "Medical Assessment of  
22 Ability to Do Work-Related Activities (Physical)" form finding  
23 Plaintiff capable of performing a limited range of light work (A.R.  
24 448-51); and (2) Dr. Raju's September, 2014 General Relief "Report of  
25 Examination" form, indicating that Plaintiff is unsuitable for any  
26 employment and limited to "no lifting, prolonged sitting or walking"  
27 (A.R. 414). See A.R. 475. The ALJ gave the "least weight" to Dr.  
28 Raju's opinions, which the ALJ described as finding Plaintiff "capable

1 of less than sedentary exertional work," reasoning:

2  
3 Although Dr. Raju is a treating physician who had a treating  
4 relationship with the claimant since 2014, the findings from  
5 his examinations of the claimant were generally mild. For  
6 instance, Dr. Raju noted the claimant exhibited decreased  
7 lumbar flexion and extension due to pain, but he found he  
8 claimant was neurologically intact and observed the claimant  
9 ambulate without assistance. The undersigned has given  
10 least weight to Dr. Raju because his opinions are  
11 inconsistent and not well-supported by his objective  
12 findings.

13  
14 (A.R. 475-76 (internal citations omitted)).

15  
16 The vocational expert had testified that, if a person were absent  
17 two times a month there would be no jobs that person could perform  
18 (A.R. 581; see also A.R. 88-89 (vocational expert also testifying in  
19 prior administrative hearing that a person could not maintain  
20 employment if absent two days a month)). Despite this testimony and  
21 despite the Court's remand order in the Prior Action finding that the  
22 former ALJ provided insufficient reasons for rejecting Dr. Raju's  
23 opinion regarding Plaintiff's absenteeism, on remand the new ALJ did  
24 not even acknowledge Dr. Raju's opinion regarding Plaintiff's  
25 absenteeism (A.R. 475-76). This was error. See Flores v. Shalala, 49  
26 F.3d 562, 570-71 (9th Cir. 1995) (an ALJ "may not reject 'significant  
27 probative evidence' without explanation") (quoting Vincent v. Heckler,  
28 739 F.2d 1393, 1395 (9th Cir. 1984)). The "ALJ's written decision

1 must state reasons for disregarding [such] evidence." Flores v.  
2 Shalala, 49 F.3d at 571. "[A]n ALJ cannot in its [sic] decision  
3 totally ignore a treating doctor and his or her notes, without even  
4 mentioning them." Marsh v. Colvin, 792 F.3d 1170, 1172-73 (9th Cir.  
5 2015) (citing Garrison v. Colvin, 759 F.3d at 1012); Lingenfelter v.  
6 Astrue, 504 F.3d 1028, 1038 n.10 (9th Cir. 2007) ("Of course, an ALJ  
7 cannot avoid these requirements [to state specific, legitimate  
8 reasons] by not mentioning the treating physician's opinion and making  
9 findings contrary to it."); Salvadore v. Sullivan, 917 F.2d 13, 15  
10 (9th Cir. 1990) (implicit rejection of treating physician's opinion  
11 cannot satisfy Administration's obligation to set forth "specific,  
12 legitimate reasons").<sup>12</sup>

13  
14 **V. Remand for Further Administrative Proceedings is Appropriate.**  
15

16 Remand is appropriate because the circumstances of this case  
17 suggest that further development of the record and further  
18 administrative review could remedy the ALJ's errors. See McLeod v.  
19 Astrue, 640 F.3d 881, 888 (9th Cir. 2011); see also INS v. Ventura,  
20 537 U.S. 12, 16 (2002) (upon reversal of an administrative  
21 determination, the proper course is remand for additional agency  
22

---

23 <sup>12</sup> The ALJ's reasoning that Dr. Raju's form opinions were  
24 "inconsistent" could be a specific and legitimate reason for  
25 rejecting certain of Dr. Raju's opinions. See Batson v.  
26 Commissioner, 359 F.3d 1190, 1195 (9th Cir. 2004) (ALJ properly  
27 gave minimal evidentiary weight to treating physician's checklist  
28 opinion that did not have supportive objective evidence, and was  
contradicted by other statements); compare A.R. 414 with A.R.  
448-49. Even so, under the circumstances of the remand, the ALJ  
should have at least addressed Dr. Raju's opinion that Plaintiff  
would miss two days of work per month.

1 investigation or explanation, except in rare circumstances); Leon v.  
2 Berryhill, 880 F.3d 1041, 1044 (9th Cir. 2017) (reversal with a  
3 directive for the immediate calculation of benefits is a "rare and  
4 prophylactic exception to the well-established ordinary remand rule");  
5 Dominquez v. Colvin, 808 F.3d 403, 407 (9th Cir. 2015) ("Unless the  
6 district court concludes that further administrative proceedings would  
7 serve no useful purpose, it may not remand with a direction to provide  
8 benefits"); Treichler v. Commissioner, 775 F.3d 1090, 1101 n.5 (9th  
9 Cir. 2014) (remand for further administrative proceedings is the  
10 proper remedy "in all but the rarest cases"); Harman v. Apfel, 211  
11 F.3d 1172, 1180-81 (9th Cir.), cert. denied, 531 U.S. 1038 (2000)  
12 (remand for further proceedings rather than for the immediate payment  
13 of benefits is appropriate where there are "sufficient unanswered  
14 questions in the record"); Connett v. Barnhart, 340 F.3d 871, 876 (9th  
15 Cir. 2003) (remand is an option where the ALJ fails to state  
16 sufficient reasons for rejecting a claimant's excess symptom  
17 testimony); but see Orn v. Astrue, 495 F.3d 625, 640 (9th Cir. 2007)  
18 (citing Connett for the proposition that "[w]hen an ALJ's reasons for  
19 rejecting the claimant's testimony are legally insufficient and it is  
20 clear from the record that the ALJ would be required to determine the  
21 claimant disabled if he had credited the claimant's testimony, we  
22 remand for a calculation of benefits") (quotations omitted); see also  
23 Brown-Hunter v. Colvin, 806 F.3d at 495-96 (discussing the narrow  
24 circumstances in which a court will order a benefits calculation  
25 rather than further proceedings); Ghanim v. Colvin, 763 F.3d 1154,  
26 1166 (9th Cir. 2014) (remanding for further proceedings where the ALJ  
27 failed to state sufficient reasons for deeming a claimant's testimony  
28 not credible); Vasquez v. Astrue, 572 F.3d 586, 600-01 (9th Cir. 2009)



1 (a court need not "credit as true" improperly rejected claimant  
2 testimony where there are outstanding issues that must be resolved  
3 before a proper disability determination can be made). There remain  
4 significant unanswered questions in the present record.<sup>13</sup>  
5

6 Plaintiff asks that the Court direct the Administration to  
7 "credit as true" Dr. Raju's opinion that Plaintiff would be absent  
8 from work two days per month. Ninth Circuit authorities are in  
9 conflict regarding the availability of a remedy crediting as true  
10 improperly rejected evidence when remanding for further administrative  
11 proceedings. See Baltazar v. Berryhill, 2017 WL 2369363, at \*7-9  
12 (C.D. Cal. May 31, 2017) (and cases cited therein). Even if  
13 available, the "credit as true" remedy would not be appropriate here.  
14 The bases for Dr. Raju's opinion should be explored on remand. See  
15 Garrison v. Colvin, 759 F.3d at 1020 (court will credit-as-true  
16 medical opinion evidence only where, inter alia, "the record has been  
17 fully developed and further administrative proceedings would serve no  
18 useful purpose").

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26 <sup>13</sup> For example, it is not clear whether the ALJ would be  
27 required to find Plaintiff disabled for the entire claimed period  
28 of disability even if Plaintiff's testimony and the treating  
physician's opinions were fully credited. See Luna v. Astrue,  
623 F.3d 1032, 1035 (9th Cir. 2010).

1 **CONCLUSION**

2

3 For all of the foregoing reasons,<sup>14</sup> Plaintiff's and Defendant's

4 motions for summary judgment are denied and this matter is remanded

5 for further administrative action consistent with this Opinion.

6

7 LET JUDGMENT BE ENTERED ACCORDINGLY.

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9 DATED: February 15, 2019.

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11 /s/

12 CHARLES F. EICK

13 UNITED STATES MAGISTRATE JUDGE

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26 <sup>14</sup> The Court has not reached any other issue raised by

27 Plaintiff except insofar as to determine that reversal with a

28 directive for the immediate payment of benefits would not be

appropriate at this time.